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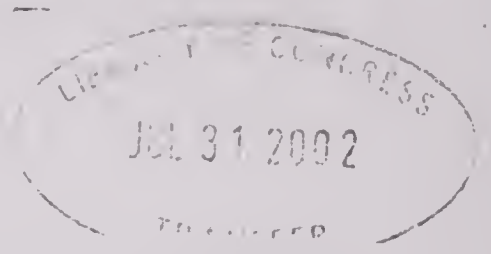

PHYSICIAN PAYMENT REVIEW COMMISSION

MONITORING ACCESS: REPORT TO CONGRESS

No. 91-5

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PREFACE

This report was submitted to Congress in accordance with the Commission's responsibility under the Omnibus Reconciliation Act of 1989 to comment on the Department of Health and Human Services Secretary's 1991 report to Congress on "Monitoring Changes in the Use of, Access to, and Appropriateness of Part B Medicare Services."

Christopher Hogan, Ph.D. and Anne Lenhard Reisinger, Ph.D. were the Commission staff members principally responsible for developing this report. Michael Millman, Ph.D. provided much needed advice early in the development of this report. The Commission's Advisory Panel on Access provided invaluable guidance throughout the preparation of this report.

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EXECUTIVE SUMMARY

Maintaining acceptable levels of beneficiary access to care is crucial to the success of Medicare physician payment reform. The new payment system, however reasonable, will not be judged a success if despite gains in access for some beneficiaries, there are deteriorations for others. Thus, adequate monitoring of changes in beneficiary access to care is critical to the successful implementation of physician payment reform.

The Omnibus Reconciliation Act of 1989 (OBRA89) directs the Department of Health and Human Services (HHS) to monitor changes in the utilization of, access to, and appropriateness of care. The HHS Secretary is directed to submit an annual report on the Department's findings to Congress. OBRA89 also directs the Physician Payment Review Commission to review and comment on the Secretary's report.

Monitoring changes in beneficiary utilization of and access to care under payment reform will be an important part of the Commission's work during the implementation phase of reform. Thus, in addition to reviewing the HHS plans, the Commission is developing its own plans for monitoring and analyzing changes in utilization and access. The Commission has convened an expert Advisory Panel on Access to assist it in both these tasks.

On May 2nd, 1991 the HHS Secretary released his first report on beneficiary utilization and access. The report describes existing and planned data systems for monitoring changes in utilization and access. It devotes several chapters to describing the HHS plans for measuring and analyzing changes in the utilization of, access to, and appropriateness of care. It also discusses possible strategies for analyzing and monitoring outcomes of care.

The Secretary's report is a good first step in the development of the Department's monitoring plans. HHS has undertaken major efforts to improve the timeliness and accuracy of Medicare claims data. The Department is also developing new data systems that will provide sorely needed information for tracking changes in beneficiary utilization and access. The Commission recommends that HHS:

- develop a standardized system for the timely and routine release of public data on changes in the utilization of and access to care;
- take steps to assure the availability of pre-reform baseline data for analysis; and
- ensure that data system development and the dissemination of data proceed rapidly.

Timely, routinely released data on the experience of beneficiaries during the implementation of payment reform will be needed to maintain beneficiary and provider confidence in the reform. In addition, data on the utilization of beneficiaries before the

implementation of payment reform will be necessary to determine if the reform has caused any changes in utilization or access.

The Commission further recommends that, in developing its plans to measure changes in utilization, access, and appropriateness, HHS:

- include plans to measure utilization and access changes during the first year of payment reform implementation; and
- more clearly specify its plans for long-run analyses of changes in utilization and access.

The HHS plans currently concentrate on analyzing long-run changes over the course of reform implementation. The Commission believes that it is imperative that the Department track utilization and access changes during the first year of implementation. Further, the Commission suggests that the Department refine its long-run analytical plans, including a special focus on vulnerable beneficiary groups and measures of access appropriate to those groups. The Commission's plans for monitoring changes in utilization and access to care, outlined in Appendix B of this report, could be used as a guide in developing the Department's plans.

MONITORING ACCESS: THE COMMISSION'S REPORT TO CONGRESS

BACKGROUND

The maintenance of acceptable levels of access to care is crucial to the success of Medicare physician payment reform. Payment reform is designed to replace Medicare's method of payment based on customary, prevailing, and reasonable charges (CPR) with a more rational and equitable pattern of payment. Over the years, the CPR method resulted in inequitable payment differentials among services, localities, and physician specialties. The reform will replace CPR with a payment method that should ensure beneficiary access to care, maintain financial protection for beneficiaries, increase equity among physicians, and constrain the growth in Medicare spending.

The payment reform is designed to achieve its goals through a resource-based fee schedule, limits on balance billing, and volume performance standards. The Medicare Fee Schedule will help to ensure beneficiary access to care and increase equity among physicians by rationalizing payments for physician services. Increases in payments for primary care services and decreases in payments for surgical and technical procedures will reduce payment disparities among specialties and services. By reducing geographic variations in physician payment, the fee schedule will reduce payment disparities among localities. Reducing these payment differentials will not only result in more equitable treatment of physicians, but should also help to ensure that beneficiaries will have more uniform access to care. By limiting balance billing, the reform will provide financial protection for beneficiaries. Volume performance standards will constrain spending growth.

The new payment system, however reasonable, will not be judged a success if despite gains in access by some, there are deteriorations for others. Thus, adequate monitoring of changes in beneficiary access to care is critical to the successful implementation of physician payment reform.

The Omnibus Reconciliation Act of 1989 (OBRA89) directs the Secretary of the Department of Health and Human Services (HHS) to monitor changes in beneficiary utilization of and access to care and to report annually to Congress on its findings. The Secretary is to report on:

- changes in the utilization of and access to services, by geographic area, population category, and type of service; and

- possible sources of inappropriate utilization, and factors underlying changes in utilization and access, including factors relating to different services and to geographic and demographic variations in utilization.

In addition, the Secretary may offer recommendations on: measures to address identified patterns of inappropriate utilization, improvements in utilization review, physician education or patient education, steps to address any problems of beneficiary access to care made evident by the monitoring process, and on any other matters that the Secretary deems appropriate.

The Secretary issued his first report to Congress on May 2, 1991. OBRA89 directs the Commission to comment on the HHS report when it is issued each year. The Commission's comments were developed in consultation with its Advisory Panel on Access.

This report conveys the Commission's concerns about the 1991 HHS plan for monitoring changes in the utilization of and access to care. The first section summarizes the discussion in the Secretary's 1991 report. The next section discusses the Commission's recommendations for action by HHS. Finally, the report discusses the Commission's role in the process of monitoring changes in access to care.

THE SECRETARY'S 1991 REPORT

The HHS report emphasizes the importance of developing data systems that will supply the information needed to monitor changes in utilization and access. Over the last several years, HHS has been improving upon existing data systems and developing data systems. Recent improvements include: standardized definitions for Part B claims data, the addition of unique physician identifiers to claims data, improved timeliness and accuracy of claims data because of the OBRA89 requirement for direct submission of claims by physicians, and the development of the National Claims History System (NCH). Each of these developments should improve the accuracy and timeliness of Medicare claims data.

Data systems under development by HHS include the Current Beneficiary Survey (CBS), the Uniform Clinical Data Set (UCDS), and the Medicare Beneficiary Health Status Registry (Registry). The CBS is a longitudinal survey of a large sample of Medicare beneficiaries. It will gather information on the beneficiaries' utilization of and expenditures for medical services, health status and functioning, as well as the beneficiaries' satisfaction with and perceptions of problems in gaining access to care. In addition, the CBS will be linked to Medicare claims files, making available detailed data on actual utilization. The Registry is a proposed longitudinal data base that would include a beneficiary survey and claims files which would allow tracking of the utilization and health status of a sample of beneficiaries for several years after the time of entrance into the Medicare program.

The HHS report first discusses the Department's proposed efforts to track changes in beneficiary utilization. HHS plans to track changes in overall volume, changes in the volume and mix of services across areas, changes in the use of specific types of services, and changes for special population groups. The report also discusses the problems and issues with interpreting these volume changes.

It goes on to outline the Department's plans for analyzing changes in access to care. HHS plans to center its analyses around measures of barriers that beneficiaries encounter in attempting to use services and the extent to which beneficiaries receive medically necessary care. The CBS will be the major source of information on barriers to care. Claims data will be used to analyze patterns and changes in the receipt of medically necessary care.

The HHS report discusses the Department's approach to monitoring changes in the appropriateness of care. It notes that monitoring appropriateness will require the development of guidelines for appropriate care and measuring Medicare beneficiary use against those guidelines. HHS plans to rely on organizations such as the Agency for Health Care Policy and Research as a source of practice guidelines. The HHS Health Standards and Quality Bureau, through Peer Review Organizations (PRO), will do the monitoring of appropriateness of care. The Department will attempt analyze whether any trends in appropriateness are caused by payment reform.

Finally, the report outlines the Department's long-term approach to monitoring changes in the outcomes of medical care that beneficiaries receive. The Department's analyses will center around three important outcomes of care: functional status, the need for follow-up care, and survival. Claims data, the CBS, PRO data and the Registry will supply the information for the Department's analyses.

RECOMMENDATIONS FOR HHS ACTION

Monitoring of changes in beneficiary utilization of and access to care under physician payment reform will be a vital HHS function in coming years. While the Department's is developing data systems that will collect timely and usable information, the Commission recommends that HHS:

- develop a standardized system for the routine release of public data on changes in utilization of and access to care;
- take steps to assure the availability of baseline data for analysis; and
- ensure that data system development and the dissemination of data proceed rapidly.

The Commission further recommends that, in developing its plans to measure changes in utilization, access, and appropriateness, HHS:

- develop plans to measure utilization and access changes during the first year of payment reform implementation; and
- refine its plans for long-run analyses of changes in utilization and access, including a special focus on vulnerable beneficiary groups and measures of access appropriate to those groups.

The following section discusses the Commission's recommendations in more detail.

Data Systems

Timely and accurate data on the utilization experience of Medicare beneficiaries will be vital to the success of efforts to measure changes in access to care under physician payment reform. HHS has made large strides toward developing data systems that will produce detailed utilization data in a timely fashion. New data sources being developed by HHS such as the Current Beneficiary Survey, the National Claims History System, the Medicare Beneficiary Health Status Registry, and the Uniform Clinical Data Set will be important sources of information on the utilization patterns of Medicare beneficiaries.

These new data sources will provide much more detailed utilization data than is currently available. The CBS will provide information on beneficiary perceptions of changes in access to care. Linked to both Part A and Part B claims files in the NCH through the Common Working File (CWF), the CBS will also allow tracking of the actual utilization experience of respondents. The UCDS will allow detailed clinical analyses of the medical treatment beneficiaries receive. The Registry should allow tracking of changes in health status and utilization for a cohort of beneficiaries from the time of entrance into the program.

The new data systems will also make data available much more quickly than it is currently. The CBS data should become available for analysis 4-6 months after the completion of a round of data collection. The CWF claims authorization process will reduce the lag between the time a claim is paid and when the record of the claim becomes available for analysis from a year or more to close to half a year. The HHS efforts to develop more timely data systems are laudable. HHS should do all it can to keep up this momentum to get these data systems fully operational.

There are, however, two major problems with the current data system plans. First, in order to assure the timely release of data to the public, HHS should develop a standardized data reporting system. Additionally, gauging the effects of payment reform on access will require the availability of data on the experience of beneficiaries in the period prior to the implementation of reform.

Standardized Reporting System. The public release of data on changes in access is important to maintaining beneficiary and provider confidence in the payment reform.

Beneficiary groups, physician organizations and independent researchers concerned with changes in access should be able to obtain data with which to examine improvements or deteriorations in access under payment reform. The HHS plans do not include mechanisms for assuring that data is released routinely to the public. To facilitate the timely release of public data, HHS should develop a standardized series of regularly released reports on measures of beneficiary access to care.[1] This information should be released in forms that are relevant to the issues being analyzed. The reports should include changes in utilization and measures of access to care by geographic area and for potentially vulnerable segments of the beneficiary population.

Public issuance of these data should be more frequent than the Secretary's annual report to Congress. While the Secretary's annual report should include the Department's interpretation of these data, more frequent public release of this information will allow other interested parties to interpret these data as well.

Baseline Data. The HHS discussion of data systems does not recognize the importance of developing good baseline data for the period prior to implementation of payment reform in January 1992. The Medicare Fee Schedule will be a significant change in Medicare payment policy, and about one-third of the total change payment levels will occur in the first year of implementation. Information on the period prior to the first implementation year will be necessary to measure changes in access to care due to payment reform.

According to the HHS report, the first round of CBS data collection will not begin until 1992, rather than in 1991 as originally planned. HHS staff have subsequently indicated, however, that the report was in error and that data collection will begin in the Fall of 1991. Because of the need for baseline data to evaluate the effects of payment reform, the Commission considers it imperative that the first round of data collection of the CBS begin on schedule in the fall of this year.

Baseline claims data for the period before 1992 will also be needed to assess changes in access. To measure the effects of the changes, it will be important to compare utilization patterns from claims data for years prior to 1992 with the patterns in 1992 and beyond. To facilitate the development of information on the pre-1992 experience, HHS should release 1990 and 1991 claims data as soon as possible.

Timeliness of Data. In addition to the data system problems identified above, the Commission wishes to emphasize the importance of timely release of data from Medicare claims files, the CBS, the Registry and the UCDS. The Department should make every

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[1] The routine reporting of labor statistics from the Bureau of Labor Statistics is an analog for this type of data reporting.

effort to see that the time between data collection and the dissemination of data to the Commission and other researchers is minimal.

Measuring And Analyzing Changes In The Utilization Of And Access To Care

The HHS report includes no plans for short-run (ie. during 1992) monitoring of changes in access and lacks detail on the Department's analytical approach to long-run analyses of access to care. It is imperative that HHS attempt to monitor changes in beneficiary access during the first year of payment reform. Both short and long run analyses will require consideration of the beneficiary groups whose access to care may be affected by payment reform and appropriate measures of access to care.

Short-run Analyses. Physician payment reform could cause significant changes in the levels of payment for various types of physician services. Under the Medicare Fee Schedule, payments for evaluation and management services, on average, will rise while payments for surgical and technical procedures will fall. Payments will typically increase in rural areas and fall in urban areas. Payment levels could change quite substantially. When the Medicare Fee Schedule is fully implemented, fees for many surgical and technical procedures will fall roughly 30 percent, while fees for primary care services will rise roughly 30 percent. At the same time, physicians' ability to bill beneficiaries for the balance of their charge will be substantially limited. By 1993, balance billing for any service will be limited to just over 9 percent of the fee schedule amount for participating physicians. Despite the balance billing limit, beneficiary copayments could rise for services, like primary care, that will increase under the Medicare Fee Schedule.

Since the Medicare Fee Schedule will be phased in over a number of years, only part of the payment shifts will occur in the first year of implementation. Approximately one-third of the total change in payment rates will occur in 1992, however, more than in any other single year. These first-year payment level changes are anticipated to be particularly large for some services. If these changes in physician payment or in beneficiary liability for the balance of the physician bill cause changes in access to care, these effects may well appear during the first year of implementation and could continue to develop over the full course of implementation. It will be important, therefore, to monitor any changes in beneficiary access to care during 1992 as well as changes that occur over the entire implementation period.

The HHS monitoring plans concentrate primarily on the long-run analysis of access changes. HHS should be developing plans to measure any changes in access that occur during the initial phase of payment reform implementation. While it may be difficult in the first year to pinpoint with any surety access changes due to payment reform, HHS should attempt to track major changes or problem areas during the first year. Early identification of significant problems will allow for refinement of the policy before it is fully implemented.

The data required to monitor short-run changes in access to care should be readily available to HHS. Claims data through the CWF will be available routinely throughout 1992. HHS could identify geographic areas or procedures with the largest payment changes and track utilization changes through the claims data. It could also identify potentially vulnerable beneficiary groups and track their utilization experience during 1992. Claims data from prior years would provide a baseline against which to gauge improvements or deteriorations in access to care. Information from the first round of the CBS could also point to potential problem areas or beneficiary groups. In addition to these large data sets, the Department could consider other sources of information on short-run changes in access. Beneficiary focus groups and surveys of carriers, for example, might help to identify short-run access problems.

Long-run Analyses. HHS's long run monitoring plans could be considerably improved with a more detailed consideration of measures of access to care and approaches to analyzing changes in access. The HHS report identifies three "definitions" of access: "measures of financial aspects surrounding access to care, ...the nature and prevalence of barriers to securing care,...[and] whether beneficiaries receive medically necessary services." The report briefly discusses several strategies for analyzing changes in these measures of access.

As the HHS report recognizes, access is not easily definable and is thus not easily measurable. HHS's three definitions of access to care could be operationalized in a number of different ways. The Commission, with the advice of its Advisory Panel on Access has developed a list of measures that HHS should consider using in its analyses (see Appendix B).

HHS's analytical strategies for monitoring changes in access to care also need more development.[2] As the Commission's workplan described in the next section and in Appendix B illustrates, a number of approaches to measuring changes in beneficiary access to care could potentially yield valuable information on changes in access. In particular, the Commission recommends that HHS consider focusing analyses on potentially vulnerable groups of beneficiaries.

COMMISSION'S MONITORING PLANS

Monitoring changes in beneficiary utilization of and access to care under payment reform will be an important part of the Commission's work during the implementation phase of reform. Thus, the Commission is developing its own plans for monitoring and analyzing changes in utilization and access.

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[2] The report states that "part of HCFA's research agenda in access to care is described in a forthcoming grant announcement." The grant announcement may contain more detail on the HHS plans.

The Commission's initial monitoring and analysis activities will focus on changes in utilization and access rather than on appropriateness. The Commission has chosen this strategy in the belief that during the initial years of payment reform implementation, deteriorations and improvements in access to care are of principal concern and are more measurable than changes in outcomes or appropriateness of care. Analyses of changes in appropriateness and outcomes are important and may be included in later phases of the Commission's workplan, but they require information on patterns of care across long time periods.

OBRA89 required that the Commission consult with a panel of experts in commenting on the Secretary's report. The Commission convened a panel of highly knowledgeable individuals including physicians, beneficiary representatives, and health services researchers (see list of members of the Advisory Panel on Access in Appendix 1). The Commission saw the value of making broader use of this group, not just to comment annually on the Secretary's report, but to advise on the Commission's workplan in this area.

In February 1991, the Advisory Panel on Access began working with Commission staff to develop plans to monitor and analyze changes in access. The Commission's workplan includes both short-run (during the first year of payment reform implementation) and longer-run analyses. The Panel helped to identify potentially useful measures of access to care and strategies for tracking changes in those measures. The Commission's workplan, summarized briefly below, is discussed in more detail in Appendix B.

The Commission analyses will employ a number of different measures of access. For example, access will be measured by the use of primary care and preventive services. Measures of primary care use include physician visit rates, the number of home visits, the ratio of outpatient visits to hospitalizations, and emergency room visits. The use of preventive services such as mammography and immunizations will also provide a measure of access to care. Another possible measure of access relies on sentinel events, health care incidents that either should not occur or should occur only rarely if beneficiaries have timely access to adequate primary care.[3] The stage of disease at first treatment and mortality may also be indicators of access.

Several areas of analysis will center around measures of provider activity or provider behavior, since beneficiary access may be affected by physician responses to changes in fees under the Medicare Fee Schedule. For example, changes in Medicare payment rates could cause physicians to limit the number of Medicare patients that they treat. Therefore, changes in the concentration of Medicare visits among physicians may be an indicator of changes in access. The number of beneficiaries changing physicians might be an additional indicator of physician willingness to serve Medicare beneficiaries. Also,

[3] Hospitalization with uncontrolled diabetes is an example.

increased use of public hospital facilities by Medicare beneficiaries may be an indicator of reduced access to private physicians.

Some of the monitoring of changes in access will center on potentially vulnerable groups of beneficiaries. For example, analyses will track changes in access for beneficiaries with few financial resources. These beneficiaries include those without supplemental coverage (Medigap) and low-income beneficiaries. Approximately 20 percent of beneficiaries have neither Medicaid coverage nor Medigap insurance. Qualified Medicare Beneficiaries (QMBs), those beneficiaries whose cost sharing amounts are paid by Medicaid but who receive no other Medicaid services, could be adversely affected by changes in physician payment. Dual eligibles, beneficiaries receiving both Medicare and Medicaid, may also face new barriers to access.

The Commission will also track those beneficiaries with special medical needs or that are difficult for physicians to care for. Special attention will be given to monitoring access for the institutionalized, the mentally and physically disabled, and the very elderly.

APPENDIX A
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APPENDIX B
DRAFT WORKPLAN ON ACCESS TO CARE

BACKGROUND

The Physician Payment Review Commission's Advisory Panel on Access was convened to help the Commission develop comments on the Secretary of Health and Human Services' report on utilization, access, and quality. To achieve this end, the Commission asked its Panel on Access to outline a feasible system for monitoring changes in beneficiaries' access to care. The Panel met on February 15, 1991 and suggested a number of approaches in this area. At a second meeting on April 22, 1991 the Panel refined a workplan for monitoring access to care.

This appendix summarizes the Commission's draft workplan for monitoring access to care. It brings together both a conceptual framework and detailed technical information on HCFA data processing systems and on the calculation of various indicators of access. In addition, it presents options for monitoring changes in Medicare beneficiaries' access to care using data that are collected currently or will be routinely collected beginning in 1992.

MONITORING ACCESS: THE CONCEPTUAL FRAMEWORK

When considering how to measure access, the Panel favored an approach of monitoring trends in various access measures for very tightly defined populations. Broadly-based aggregate utilization statistics are insufficient for detecting changes in access to care. Monitoring must focus on the types of individuals and geographic areas that are most vulnerable to reductions in access or that are most in need of increased access to care. Measures of access to care must be as specific as possible.

In considering when to monitor access, the Panel suggested a two-pronged strategy. First, some means to monitor access should be in place prior to January 1, 1992. This will assure timely response to any problems that may develop, and may provide much-needed objective data during the early implementation of Part B payment reform. However, more refined measures of access should be developed in later years as better and more comprehensive data become available.

In considering who should monitor access, the Panel had fewer substantive recommendations. The Health Care Financing Administration (HCFA) has the most direct use of Medicare claims and other files. The Commission strongly endorses the timely public release of utilization and access statistics by HCFA. This will allow all interested parties to track developments in beneficiary access to care. Finally, the Commission will undertake its own research on beneficiary access to care based on HCFA administrative data and other data sources.

TECHNICAL NOTES ON MEASURES OF ACCESS

The Panel's approach to monitoring access is based on comparing trends in utilization across various populations and geographic areas. The Panel identified the specific

geographic areas, vulnerable populations, and measures of utilization most relevant to monitoring access. Many of these access measures may feasibly be tracked using HCFA administrative data, but others may require special data collection efforts.

The geographic areas of interest are of two types: areas in which fees are low or falling, and areas in which financial or health care resources are already stretched thin. Identification of the first type of area is fairly straightforward using Medicare and private-sector claims files. Identification of the second type of area may sometimes be more difficult. In particular, inner city areas and Health Professional Shortage Areas (HPSAs) are based on small and diverse geographic units and will require considerable effort to identify.

Vulnerable populations are again of two distinct types: those with few financial resources, and those with special health care needs. It is possible to identify the elderly poor and near-poor beneficiaries when states purchase Part B coverage on their behalf, for example, dual eligible Medicare/Medicaid beneficiaries and Qualified Medicare Beneficiaries. However, HCFA administrative data may not allow other financially vulnerable populations, such as those without Medigap coverage, to be identified. Beneficiaries with special health care needs include the institutionalized, the mentally and physically disabled, persons with end stage renal disease (ESRD), and the very elderly. Most of these populations could be adequately tracked using administrative files and Social Security Administration data.

Tightly-targeted measures of access can be constructed from several types of utilization data. First, clinically-based utilization measures may indicate the presence of access barriers. Hospitalization for certain "sentinel events", presence of advanced stages of a disease, and excess mortality may all indicate inadequate primary care. Other utilization measures indicate good access to care, including the use of primary care and preventive services. All of these measures are fairly easy to calculate from Medicare administrative data.

Other measures center around providers rather than beneficiaries. Public urban hospitals and clinics are generally thought to be providers of last resort for many populations. Hence, a shift of beneficiary care to these settings could signal difficulty in receiving care in private physician offices. Similarly, an increased concentration of Medicare services among fewer physicians might indicate reduced access to mainstream health care. However, tracking the number of physicians serving Medicare beneficiaries appears difficult prior to 1992.

TECHNICAL NOTES ON SOURCES AND USES OF DATA

In the short run, the principal source of timely data is HCFA's core claims file, the Common Working File (CWF). The CWF is a new claims processing system that captures all Part B physician services claims in a single centralized location. Extracts from this file could be used immediately to calculate access measures based on service utilization. Alternatively, special-purpose surveys of beneficiaries or physicians might be commissioned during the early stages of implementation of physician payment reform.

Over the longer term, many additional sources of data become available. Part B Medicare Annual Data (BMAD) files summarize a year's worth of claims activity, and could be used in much the same way as the CWF. In addition, national surveys of beneficiaries and physicians may be used to look at access issues directly. Finally, several significant sources of non-Medicare data may be available for tracking utilization trends in the non-Medicare population. Divergences between Medicare and non-Medicare utilization could signal a loss of access by beneficiaries.

SUMMARY AND TENTATIVE WORKPLAN

The Commission's first priority is to develop feasible access measures that may be implemented prior to 1992. Given the limited time frame, monitoring should probably focus on readily available HCFA claims data sets consisting of Part B claims for the standard 5 percent beneficiary sample, and Part A inpatient claims for all beneficiaries. Several years of these files are available, allowing the various measures of access to care to be tested on historical data.

The Commission will also consider available survey information and will consider fielding its own survey of beneficiaries. While perhaps less precise than claims-based analysis, surveys could directly address questions of access to care in a timely fashion.

Finally, the Commission reiterates its belief that HCFA should routinely report detailed Part A and Part B utilization statistics in a manner that will allow other interested parties to assess changes in beneficiaries' access to care. A common set of data available to all would enhance dialogue on beneficiaries' access to care and preserve confidence in the Medicare program.

MONITORING ACCESS: THE CONCEPTUAL FRAMEWORK

Three broad strategic areas need to be addressed in monitoring the access impacts of physician payment reform. First, how should access to care be measured? Second, when should it be measured, in the short run or in the long run? Finally, who should be responsible for monitoring changes in access?

HOW TO MEASURE ACCESS TO CARE: AREAS, POPULATIONS, AND MEASURES

The Panel suggested monitoring access by tracking trends in utilization across populations and geographic areas. Populations or areas most vulnerable to reductions in access will be contrasted to populations and areas in which access problems are unlikely to develop. Declines in access measures for those most at risk relative to those least at risk would be a warning that beneficiaries may be having a greater difficulty obtaining adequate care.

This approach requires that the areas, populations, and measures be as tightly defined as possible. Access is likely to deteriorate first for small subsets of the population or for specific types of medical care. For example, problems may be more likely to arise in those geographic areas having the steepest fee reductions. Within those areas, the impact might be most strongly felt by beneficiaries with exceptional needs, such as the home-bound, institutionalized, or mentally disabled. For these beneficiiaries, reductions might first appear in specialty services. A broad-based, untargeted approach to monitoring access might never detect these deteriorations in access or might detect changes only after substantial problems had already developed.

Because such a narrowly targeted approach is called for, the Panel identified specific geographic areas, vulnerable populations, and measures of access. These are outlined briefly here, and in more detail in a later section of this appendix.

Geographic Areas

The panel identified a number of geographic areas that should be studied separately. First and most obviously, areas where Medicare rates will be substantially below private sector rates, and areas where Medicare rates will fall most substantially should be analyzed separately. Physicians in these areas will have the lowest financial incentives to serve Medicare beneficiaries. Second, areas with physician shortages, such as Health Professional Shortage Areas (HPSAs) should be given particular attention. Finally, inner city areas and frontier rural areas generally suffer both from poverty and from a lack of providers, and so would be most vulnerable to reductions in access if even a few physicians became reluctant to treat Medicare beneficiaries.

Vulnerable Populations

The Panel identified several vulnerable populations that should be the focus of monitoring efforts. One such population consists of beneficiaries who have limited ability to pay for services. This includes beneficiaries without supplemental coverage (often referred to as Medigap), and low-income beneficiaries, including Qualified Medicare Beneficiaries (QMBs) and beneficiaries receiving both Medicare and Medicaid. A second vulnerable population consists of beneficiaries with complex or ongoing medical needs, individuals who may be more difficult or less remunerative for physicians to treat. This population includes the institutionalized, the mentally and physically disabled, persons with end stage renal disease (ESRD), and the very elderly.

Measures Of Access

The panel suggested several approaches to measuring changes in access to care for these target populations. One such approach was the incidence of sentinel events, which are medical events which should happen only rarely if beneficiaries are receiving adequate care. For example, hospitalizations for diabetes and hypertension might indicate insufficient primary care and outpatient management. A second measure was the stage of disease at presentation. Persons with poor access typically present at an advanced stage of disease. Similarly, excess mortality may be an indicator that proper care is not being received. Other measures are more directly linked to good access to care. These include the use of preventive services, and the use of primary care services. In both cases, higher use rates indicate a lower likelihood of poor access to care.

Other measures of access were based on providers of care. First, the Panel suggests that utilization in public urban hospitals and clinics may be an indicator of poor access. These institutions are generally thought to be providers of last resort for many populations. Hence, a shift of beneficiary care to these settings could signal difficult in receiving care in private physician offices. Second, the Panel suggested that an increasing concentration of care among fewer physicians might indicate a loss of access to mainstream medical care. The Panel suggested tracking the fraction of physicians serving Medicare patients, the concentration of Medicare services across physicians, the number of beneficiaries changing physicians, and reasons for loss of usual source of care.

WHEN TO MEASURE ACCESS TO CARE: IMMEDIATELY AND IN THE LONGER TERM

In considering when to measure access, the Panel suggested that some system for monitoring access should be in place by 1992, and that more detailed analysis should be performed in later years as more complete and detailed data became available. The large payment changes that will occur in 1992 suggest that access problems, or at least the perception of access problems, may begin to develop immediately after implementation of payment changes. Thus, a system for monitoring changes in access should be in place prior to the implementation of payment reform in 1992. However, monitoring is also needed in the longer run. Many of the effects of the payment changes, and many of the

more detailed datasets will not be available until several years into the transition to the new physician payment rates.

The Immediate Need For Measures Of Access To Care

There are three rationales for putting some access monitoring process into place in time for the 1992 implementation of physician payment reform. First, there may be immediate and real reductions in access due to the payment changes. Second, it may require several years to identify and address problems in access if we rely solely on detailed annual datasets such as the Current Beneficiary Survey. Finally, hard evidence on changes in access to care may be particularly useful during the initial phases of payment reform.

The first factor to consider is the probability that problems in access will develop soon after January 1, 1992. This is of course difficult to assess. Part B payment restraints through 1989 do not seem to have caused reductions in access for the typical beneficiary. However, this may not extrapolate to the large payment changes that will take place in 1992 and later years.

Perhaps the most positive statement that can be made is that problems are more likely to occur with physician payment reform than they were with Medicare hospital payment reform. A comparison of physician payment reform and the Medicare Prospective Payment System (PPS) shows why that may be true.

First, payments during the initial years of PPS were quite generous, with hospital operating profit margins exceeding 14 percent on average. In contrast, real Part B fees have fallen 15 percent since 1988, and may continue to fall after 1992 due to certain technical aspects of the transition to the new fee schedule. Second, PPS generated smaller initial changes in payment rates, with 75 percent of inpatient operating payments and 100 percent of other payments (capital, outpatient services) based on the hospital's own cost experience. In contrast, all provider-specific rates disappear during the first year of physician payment reform, and locality-wide average payments are the only vestige of the current system that will remain after 1991. Finally, the typical hospital may have been unable to reduce its Medicare patient load. Medicare accounts for about 40 percent of hospital inpatient revenue, and the decision to admit patients is made by the physician, not the hospital. In contrast, Medicare constitutes a smaller proportion of revenues for many specialties, and physicians have a direct financial interest in the level of Part B fees.

The second factor arguing for immediate monitoring of access is the length of time necessary to obtain, analyze, and act upon the detailed annual datasets to be produced by HCFA. The first of these datasets will appear only in late 1993 or early 1994. The cycle of analysis, recommendation, and legislation could take another year, meaning that problems occurring in 1992 might not be corrected until 1995. Given this lag, it may not be advisable to wait for complete annual data sets before judging increases or decreases in access to care.

A final factor to consider is the need for solid objective data during the initial transition to the fee schedule. Any program change of this magnitude is likely to generate considerable criticism and negative anecdotal evidence. This could create a perception of

reduced access even if access is not in fact reduced. Clear and unambiguous information during this period may help maintain the integrity of the reforms during their initial implementation.

The Need For Long-Run Monitoring Of Access

There are several reasons to develop measures of access that cannot be implemented until several years after 1992. First, many of the potential impacts of payment changes may take some time to appear. Second, better data become available as time passes. Third, a longer time frame allows more fine tuning and testing of access measures.

One reason to pursue access monitoring over the longer term is that the impacts of payment reform may not be fully felt until years later. First, while payment rates will change most dramatically in 1992, rates will continue to change through 1996. Many physician practices seeing a decline in fees in 1992 will probably see further declines in later years. Second, physicians and beneficiaries may take several years to react to the new rates, modifying practice patterns and payer mix over the course of the transition. Finally, the health effects of some types of reduced access to care may take years to develop. In particular, measures based on death rates and on hospitalization for sentinel events may not change until well after access to primary care has declined.

A second reason for planning a long-term access strategy is that more complete and detailed data become available. Immediately available data may be limited to simple claims writeoffs. These files are always subject to uncertainty due to fluctuations in the number of outstanding unprocessed claims (claims runout), and they will not include information on such items as health status. Annually produced datasets would include the Current Beneficiary Survey (CBS) and the Part B Medicare Annual Data (BMAD) files from HCFA, and the Health Interview Survey from the National Center for Health Statistics. These files are not subject to the uncertainties caused by claims runout and they contain more complete information on the beneficiaries. However, complete annual data are typically not available until one to two years after data collection ends, meaning that the first detailed analysis of the access impacts of the 1992 changes cannot be made until late 1993 or early 1994.[1]

Finally, much of the developmental work for the proposed measures of access still needs to be done. Reliable measures of access may not be available in time for the initial implementation of payment reform. In the interim, research may be directed toward developing and testing new measures of access to care for implementation on the more complete datasets.

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[1] For example, data from the first set of post-1991 CBS access questions will be available in June 1993 at the earliest, but final tabulations will not be available until December 1993. Similarly, the 1992 BMAD files will probably be released around the end of 1993.

WHO SHOULD DO THE ANALYSIS?

Perhaps the most difficult question to answer at this time is who should monitor access. Clearly the burden of work must rest primarily with HCFA, since HCFA will have the use of all Part B claims data. In addition, the Commission may wish to establish greater access to Medicare claims files for the purpose of monitoring changes in beneficiaries' access to care. Finally, the Panel urges that the Secretary routinely release utilization data that would allow any interested parties to track measures of access.

Practical considerations alone suggest that HCFA must play the major role in monitoring access to care. First, the principal source of Medicare claims data is huge. Estimates of the size of one year of Common Working File Part B records range from 1500 to 7000 standard reels of computer tape, depending upon what data items are included. Because HCFA staff will necessarily have more direct access to this data, they will be better able to calculate some of the measures of access. Second, some elements of the data set cannot be released to individuals outside Health and Human Services. In particular, the Unique Physician Identification Numbers (UPINs) probably will not be available to researchers, although some scrambled form of the UPINs may be made available. Thus, detailed analysis of certain aspects of the data such as characteristics of physicians may best be done by HCFA personnel.

However, other parties may also play a part in monitoring access to care. The Commission may wish to perform its own analyses of HCFA claims files to assure that certain measures of access are calculated. However, given the lack of specific detail in the Secretary's report on utilization, access, and quality (DHHS 1991), it is difficult at this point to say what measures the Secretary actually plans to calculate and publish. Thus, it is unclear to what extent the Commission will engage in actually analyzing claims files in its efforts to monitor access.

Some analyses of data other than HCFA claims files may more appropriately be done under the auspices of the Commission rather than by HCFA. For example, physicians or beneficiaries might respond to surveys differently depending upon the sponsor. Thus, the Commission could play a valuable role in supplementing the HCFA research agenda in these areas.

Finally, the Commission recognizes that the timely release of data by HCFA as a crucial element in this plan. Many of the data sources are too large to be released in their entirety by HCFA. However, useful summary statistics could be produced and made available to interested parties. Routine release of such summary data, with or without further analysis by HCFA, would allow interested parties such as beneficiary organizations to track changes in access to care.

TECHNICAL NOTES ON MEASURES OF ACCESS

This section of the workplan collects background information on the geographic areas, vulnerable populations, and measures of access identified by the Panel. The underlying question is whether these areas, populations and measures can be identified using HCFA claims files. Table 1 at the end of this section provides a summary of the areas, populations, and measures discussed here.

GEOGRAPHIC AREAS

The Panel identified several geographic areas of interest. This section reviews some evidence on the ability to identify these areas and track beneficiaries within these areas using Medicare administrative data.

Frontier Rural Areas

Frontier rural counties are counties with fewer than six inhabitants per square mile. With only a handful of exceptions, these counties all are west of the Mississippi river. These areas are marked by relatively thinly-spread health care resources, and inhabitants are generally thought to have to travel further to obtain medical care. In these areas, access could be jeopardized if only a few providers decided not to see Medicare beneficiaries. In 1988, 1.2 percent of Medicare beneficiaries lived in frontier rural counties.

It is a relatively straightforward task to identify frontier rural counties using the Area Resource File (ARF). Once those counties are identified there are two ways in which claims information may be obtained. First, HCFA already processes many claims into county aggregates. Thus, county of residence aggregate files could readily be made available. However, these files are processed only with a considerable lag, usually contain only summary information, and would not serve for a rapid analysis of changes in utilization just pre and post the introduction of payment reform. Alternatively, HCFA staff may draw samples of records from the CWF based on county of residence.

Inner City Areas

Identifying beneficiaries in inner city areas is a much more difficult task than identifying those in frontier rural areas. For the purpose of tracking health care use, inner city areas are generally defined as areas with low average incomes, high poverty rates, and few health care providers. Because these areas must be defined at the sub-county level, readily-available county-level files such as the ARF are not useful in identifying them.

One approach to identifying such areas would rely on commercially available files tabulating information for individual Census tracts or ZIP codes. These files typically record information on average income. These files might be supplemented with counts of patient care physicians to generate a list of ZIP codes for a specific definition of inner-city

areas. Once ZIP codes were identified, records could be drawn from the CWF based either on the ZIP code, or more easily, based on the HICs of individuals living in those ZIP codes.

An alternative approach could be undertaken from HCFA claims files. Beneficiary ZIP code and buy-in status could be used to identify ZIP codes with a high proportion of poor and near poor beneficiaries, those who are Medicaid-eligible or who are Qualified Medicare Beneficiaries. As with the first approach, counts of physicians could then be used to identify underserved pockets of poverty within cities.

There is a potentially important complication to either of these methods. Because the ZIP code is based on the mailing address of the Social Security check, there may be leakage across the borders of inner-city regions. ZIP code zones tend to be geographically small in cities, making this a more significant problem than the similar problem faced in placing beneficiaries into frontier rural counties.

Health Professional Shortage Areas

Health Professional Shortage Areas (HPSAs) are designated by the Health Resources and Services Administration (HRSA) in the Public Health Service. HRSA has used the HPSAs to help determine the allocation of Public Health Services Corps physicians. A low physician-to-population ratio is the prime determinant of HPSA status.

Medicare currently pays a bonus payment for services provided in HPSAs. Prior to 1991, a five percent bonus was added to physicians providing services in some categories of rural HPSAs. As of January, 1991, a 10 percent bonus is paid for services provided in all rural and urban HPSAs.[1] HCFA staff provided the Commission with the following outline of claims processing for HPSAs:

Medicare Part B carriers must know which bills are paid in HPSAs because payment rates differ between HPSA and non-HPSA areas. Identification of those bills is, however, a lengthy process. It begins in the Public Health Service, which provides a "narrative list" of HPSAs to HCFA, literally a written description of each HPSA. HPSAs may be counties, Census tracts, or other geographic areas, or may be specific to particular populations within geographic areas, for example, individuals below the poverty line. HCFA passes this narrative list on to the carriers with instructions to draw maps or otherwise make information about the locations of HPSAs available to physicians.

Physicians must identify services provided in HPSAs on the claim form in order to receive the bonus payment. Prior to January 1, 1991, this was done by adding "rural" to the narrative place-of-service description.[2] Carriers, however, translated these expanded place-of-service narratives into the standard place of service codes when submitting the

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[1] Actually, the additional payment is 10 percent of the 80 percent of the bill paid directly by Medicare, or 8 percent of the allowed charge.

[2] For example, hospital inpatient - rural.

data to HCFA. Thus, prior to January 1, 1991, information on individual services provided in HPSAs was not available on HCFA claims files.[3] After January 1, 1991, however, the system for reporting HPSA services changed. Rather than using a place-of-service code, physicians were instructed to use a new HCPCS code modifier to show that the services was provided in a HPSA.[4] This modifier would be retained during claims processing, and so should be available on HCFA claims datasets. However, the extent of compliance with this new regulation is not yet known. Currently, HCFA tracks centrally only the quarterly aggregate number of checks and total bonus payments for services delivered in HPSAs.

If shortage designation is not accurately recorded, obtaining information on beneficiaries in those areas would require a considerable amount of work. HPSAs are quite complex. Even those that are strictly geographically defined can be areas from whole counties down to individual census tracts or magisterial districts. These areas will not cross-walk exactly to ZIP codes, and to date Commission staff have not found an approximate ZIP code mapping for all U.S. HPSAs.[5] Thus, such a cross-walk might have to be generated by overlaying physical maps of HPSAs with ZIP code maps.

Medically Underserved Areas

Medically Underserved Areas (MUAs) are an alternative to HPSAs for identifying areas with potentially poor access to care. The MUAs share many of the technical problems of the HPSAs. They are not defined in units that are easily traceable through the machine readable files. In addition, they are not the basis for the Medicare 10 percent bonus payment, and so are not recorded on HCFA claims files.

Areas/Specialties With Large Price Declines

The Commission's simulations will be used to identify areas and specialties within areas that will experience large fee declines during the transition to the Medicare Fee Schedule. Currently, those simulations are being fine-tuned to represent the best available data on post-1992 payment rates. Later this year, Commission staff will estimate gains and losses by specialty and payment area. Because fees are set using these payment area definitions, it will be quite easy to identify all services paid for in the various areas.

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[3] On the 1989 BMAD file, three carriers (Virginia, Louisiana, and the Railroad Retirement carrier) used a unique set of place of service codes to report services delivered in shortage areas.

[4] The HCFA Common Procedure Coding System (HCPCS) code is a five-digit code identifying the service performed by the physician. A two-digit modifier is sometimes appended to the HCPCS code to further define the service. The modifiers QB and QU are now used to indicate that a service was provided in a HPSA.

[5] One study using National Medical Expenditures Survey data cross-walked late-1970s HPSAs to ZIP codes. This took approximately two person-weeks of effort (Personal communication with Amy Bernstein, Prospective Payment Assessment Commission).

Areas With Large Medicare/Private Fee Differentials

While Medicare fee data are publicly available, there is little reliable private-sector fee information. Previous staff work with the Blue Cross and Blue Shield Association verified that there is considerable geographic variation in the gap between BC/BS and Medicare payment rates (PPRC 1990), but the BCBSA cannot identify individual areas in its analyses.

Of the potential data sources in this area pursued by the staff, the MEDSTAT data appear most promising. The MEDSTAT database is a collection of claims for approximately 100 very large employers. This data set is rather expensive, but it has a number of advantages. First, it has a fairly representative sample of private sector payer mix, including both BC/BS and commercial payers. It also has a reasonably uniform geographic distribution across urban areas, though relatively few claims are filed from rural areas.

Commission staff have contracted with MEDSTAT for the purchase of data which may allow comparisons between 1989 Medicare rates and 1989 private sector rates. From this, staff can use the Commission's simulations to project the approximate differentials that will occur in 1992 and later years. If the MEDSTAT data prove usable and reliable this analyis may be repeated in later years.

VULNERABLE POPULATIONS

The Advisory Panel on Access identified a number of populations most vulnerable to reductions in access to care. This section collects some background information on identifying those populations using the Medicare administrative files.

Old Old

This population can be easily identified from HCFA administrative data. Various HCFA eligibility files contain date of birth information, which can then be linked to the Health Insurance Claim (HIC) number (Social Security or Railroad Retirement Number plus Beneficiary Identification Code). HCFA uses the HIC on all claims processed, so service utilization by this population should be easy to track. It may be necessary for HCFA to encrypt the HICs to maintain the confidentiality of the records. However, because HCFA's encryption algorithm is unique, the Commission may also request the beneficiary information with encrypted HIC and merge the beneficiary information onto the claims.

A typical line for distinguishing the "old old" beneficiary is age 85. This would capture 10 percent of the aged beneficiary population and 12 percent of Part B outlays.

Disabled

As with the old old, HCFA administrative records allow the disabled to be identified directly. In this case, the "current reason for entitlement" field identifies all disabled beneficiaries. Disabled beneficiaries constitute about 10 percent of the beneficiary population (2.7 million disabled versus 28.5 million aged beneficiaries in 1988).

Identifying the mentally and physically disabled within this category of beneficiaries may be quite difficult. Routinely available produced Medicare statistical files do not maintain a finer breakout of the "reason for entitlement" field. However, Social Security Administration files probably do record a detailed "reason for entitlement" for the disabled. Commission staff will check with HCFA personnel to see whether type of disability recorded on the SSA files may be written onto HCFA claims records. If not, staff could try to identify the mentally disabled through patterns of service use (eg., psychiatric services). This may require a special request for data from HCFA in order to be able to attach beneficiary reason for entitlement onto the Commission's existing sample of Part B beneficiary claims.

ESRD Beneficiaries

ESRD beneficiaries are identified in the "reason for entitlement" field. In addition, the standard HCFA beneficiary sample contains records for five percent of non-ESRD beneficiaries and 100 percent of all ESRD beneficiaries. Thus, it would be particularly convenient to track utilization by this beneficiary population.

Institutionalized

Commission staff have been discussing the problem of identifying the institutionalized with HCFA personnel working on the Current Beneficiary Survey. They suggest that it may be difficult to characterize accurately the institutionalized beneficiary population.

Staff can identify beneficiaries with Part B charges in nursing home settings. In addition, some Part A payments may be identifiable for nursing home care following acute inpatient stays. However, these markers would ignore beneficiaries with no claims, and may imperfectly identify beneficiaries who are well enough to travel to physician offices or other settings for their Part B care. At the very least, Commission staff will try to benchmark counts of institutionalized individuals derived from claims analysis against counts from national surveys. In addition, this would not accurately track beneficiaries as they move into and out of institutional settings. That is, a listing of institutionalized individuals derived from 1990 data may be a poor proxy for the institutionalized population in 1992.

Buy-In Status (Medicaid, QMBs)

States may purchase Part B coverage for their Medicaid beneficiaries (dual eligibles) and for individuals near the poverty line but not Medicaid eligible (Qualified Medicare Beneficiaries or QMBs). HCFA administrative files note the buy-in status of Medicare beneficiaries, so this population could be easily identified. However, because buy-in status may change over time, there may be some discrepancies between beneficiaries identified by this method in one year and the population of beneficiaries with state buy-in in the next year.

Approximately 9 percent of beneficiaries were enrolled in Part B under state buy-in agreements in 1989. This varies considerably across states, however. For example, nearly

25 percent of Mississippi beneficiaries were enrolled under this program, while for several states approximately 3 percent of beneficiaries were so enrolled.

Payment policies regarding these beneficiaries vary considerably across states. States pay the copayments for these beneficiaries, but typically will pay these copayments only in reference to their local Medicaid fee schedules. Thus, in many states, if the Medicaid fee is less than 80 percent of the Medicare allowed charge, the physician collects no copayment. Commission staff have so far been unable to locate a listing of state policies in this area. A survey of state Medicaid programs may have to be conducted to determine which states pay at their Medicaid fee schedules and which states pay the full Medicare rate.

Ethnicity

Ethnicity is identified on several of the Medicare statistical files. The categories are black, white, other, and unknown.

The Poor

It is probably not possible to identify the non-Medicaid/non QMB poor. While it is possible, on a special request basis, to obtain files with social security income, that variable has not proven very useful in identify poor individuals in previous Commission staff work. However, some survey data may provide information on income.

MEASURES OF ACCESS

Finally, the Panel suggested several types of measures of access to care. This section provides some small amount of background detail on calculating those measures from HCFA administrative data.

Sentinel Events

The notion of avoidable illness and avoidable death underlies the sentinel event approach to monitoring access. Sentinel events are serious medical conditions which could have been avoided or from which death could have been avoided (United Hospital Fund 1988). They have been classified into events for which any incidence indicates poor care (ie., events which should never happen) and events for which a high incidence indicates poor care. Little of the existing analyses of sentinel events has focussed on the Medicare population, although under one definition 60 percent of sentinel events occur in the over-65 population (United Hospital Fund 1988).

At least two questions need to be addressed before beginning to apply the sentinel event approach to the Medicare population. First, of the sentinel events identified elsewhere, which ones are most applicable to the Medicare population? Second, how large a population is needed to guarantee a reasonably stable estimates of the incidence of sentinel events over time?

Commission staff began to examine the questions of incidence and stability for a small number of sentinel events. Criteria for identifying four sentinel events using ICD-9-CM codes on hospital discharge abstracts were taken from a recent Health Resources and Services Administration report (HRSA 1987). Part A records from the Medicare Automated Data Retrieval System (MADRS) were analyzed for a sample of about 100,000 beneficiaries residing primarily in the Los Angeles area. The annual incidence of these four sentinel events per 1000 beneficiaries varied considerably, from 0.2 events per 1000 beneficiaries for invasive cervical cancer to 19 events per 1000 beneficiaries for uncontrolled hypertension.

The relatively low incidence of these conditions means that fairly large populations are needed to obtain stable use rates. Thus, this technique probably cannot be applied to populations of fewer than 50,000 beneficiaries. In smaller populations, even very large year-to-year fluctuations could be the result of natural random variation in incidence.

Stage Of Disease

The concept of disease stage originated in oncology, where the progress of a cancer was tracked from localized involvement through systemic involvement, organ failure, and death. Individuals with poor access to primary care might first present to a physician with their disease at a more advanced stage. Thus, stage of disease at first treatment may be a good clinical indicator of access to care.

In some instances, the stage of a cancer might be subsumed into the sentinel events approach if certain subsets of ICD-9-CM codes would allow invasive and metastasized cancers to be identified. More formal approaches are available based on the diagnoses and procedures recorded in Part A hospital data. If these approaches to identifying stage of disease are not satisfactory, the success of such a project might depend on crosswalking information from cancer registry data onto the Medicare claims files. Large-scale mapping of machine-readable cancer registry data has been attempted before,[6] and there are fairly standard procedures for matching discharge abstracts to other data files.

Because the best indicator would be stage of disease at presentation, this approach would ideally require a fairly substantial time series. Such a time series might be feasible if the indicator is limited to stage at first hospitalization. Because the Medicare hospital discharge abstract files are fairly small (10 million records annually) and complete, it would be feasible to perform a retrospective search within a multiple-year window to identify a patient's first hospitalization for a given condition.

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[6] For example, the Hospital Cancer Clinical Research Project (HCCRP), a joint undertaking of the National Cancer Institute and the Agency for Health Care Policy and Research, linked data from 10 regional cancer protocol registries to a discharge abstracts provided by a few hospitals. However, the project, begun in 1984, is not yet finished, so it is difficult to tell how accurately such data may be matched.

Primary Care Utilization

The Panel suggested a number of access measures based on utilization of primary care services. These included the gross visit rate, annual probability of an office visit, number of home visits, ratio of outpatient visits to hospitalizations, emergency room (ER) visits, or ER visits as a percentage of all visits, and the distribution of office visits across beneficiaries.

With the exception of home visits, calculation of all these measures should be fairly straightforward. For home visits, there is a complication in that visits by home health agency employees might substitute for visits by physicians. Thus, counts of physician home visits might misstate the degree of home-based care delivered.

Because primary care visits are the most often-billed Part B services, these measures should at least be statistically stable. However, several panel members suggested that these measures might be poor access indicators because different beneficiaries might receive visits for different reasons (eg., preventive care versus acute care). Until the quality of the diagnosis coding on the new Part B records is known, however, it probably will not be possible to sort out the various reasons for visits.

Number Of Physicians Serving Medicare Beneficiaries

One possible adverse impact of changes in Medicare payment rates is that many physicians may seek to limit the number of Medicare patients that they treat. Hence, a reasonable indicator of good access to care would be the dispersion of Medicare services across physicians. A reduction in the number of physicians seeing Medicare patients may indicate a loss of mainstream care for beneficiaries. An additional provider-based indicator would be the number of beneficiaries changing physicians. Changes in this indicator might also show an increased unwillingness by some providers to serve Medicare beneficiaries.[7]

Technical problems with physician identifiers in the Medicare files may make this a difficult task. Prior to 1991, Medicare statistical files identified physicians only by carrier-assigned numbers. Numerous physicians could use the same number (eg., a single billing number for a group practice), while one physician might bill under several numbers.

To quantify the magnitude of this problem, Commission staff took a sample amounting to 1 percent of 1989 physician billing numbers. On a charge-weighted basis, only 30 percent of physicians used a unique identifier, with 70 percent reporting that multiple identifiers might be used by the same provider entity. This is clearly the result of variation across the carriers: eight carriers require unique numbers, while nearly all the remaining carriers allow multiple numbers per physician. About 60 percent of the billing numbers were for solo practitioners, while the remaining 40 percent were from group practices, clinics, and other practitioners. Thus it is appears unlikely that any accurate estimate of the extent of

[7] Measures of the number of beneficiaries switching physicians and the reason for loss of usual source of care will also be obtainable from the Current Beneficiary Survey.

concentration of Medicare services among physicians can be obtained from historical Medicare claims files.

HCFA is moving toward a Unique Provider Identification Number (UPIN) system, under which each MD or DO would have one and only one billing number. Currently, however, only about 40 percent of CWF records have the UPIN on them, with the rest still being reported by the old carrier-assigned numbers. The HCFA Bureau of Program Operations does not plan to enforce use of the UPIN (ie., denial of claims) until January 1, 1992. Thus, there will be no good national pre/post 1992 time series based on the UPIN.

It is possible that HCFA could map the old carrier identifiers to the new UPINs in an attempt to get some national trend data. Medicare's directory of UPINs retains up to six carrier-assigned billing numbers for each UPIN. A project to crosswalk the UPINs and the old numbers is being discussed at HCFA, and Commission staff plan to make further inquiries in this area.[8]

There may be, in addition, strong restrictions on the use of the UPIN once it is fully implemented. Whereas employees of HHS may access the UPIN files for their official duties, no provision is made for government agencies outside of HHS other than the Department of Justice in case of legal action. Thus, it is unlikely that the PPRC would be able to perform a mapping of historical data to the new UPINs on its own, and would have to rely on a HCFA-provided mapping.

Finally, HCFA has historical data on the number of physicians signing participation agreements. It is not clear, however, whether this data would be useful in tracking the concentration of Medicare services across physicians.

Profiling Physicians Serving The Underserved

An additional physician-based analysis suggested by the Panel was to profile and track those physicians serving the underserved. Ideally, Commission staff would like to use the Medicare claims files to track these physicians. If UPIN-based information is provided, staff should be able at least to analyze counts in the number of physicians after 1992. However, due to restrictions on the use of the UPIN, staff may not be able to profile the characteristics of physicians. While HCFA's UPIN directory will indicate such items as board certification, it seems unlikely at this point that such information will be made available to those outside of HCFA.

Use Of Public Institutions

The Panel suggested that increased use of public facilities might be one indicator of reduced access to private physicians. Staff have examined the potential for tracing the amount of care provided in public hospitals and other governmental funded facilities.

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[8] However, it may be impossible to count the number of physicians within groups serving Medicare beneficiaries, since in some instances all physicians within a group used the same billing ID in the historical data.

On the inpatient side, this is a relatively straightforward task. The HCFA Provider of Service file will allow the HCFA hospital identifiers to be selected for urban public hospitals. These hospital identifiers are keyed onto the Medicare Part A files, allowing the inpatient care in these facilities to be tracked easily.

On the outpatient side, however, this may be much more difficult. Each visit to a hospital outpatient department generates a facility charge. The bill for this facility charge uses the same hospital identifier as the inpatient bill, so bills from public hospital OPDs should be recognizable. However, the hospital outpatient files have historically been among the least usable of HCFA datasets, and have never been publicly released. In addition, diagnoses have been coded using ICD-9-CM codes, and CPT codes have only recently been required. So far, compliance with the CPT coding requirement seems spotty, so it may not be possible to count individual services very accurately in this file. It probably is not possible to track public hospital use through physicians' bills. The provider number on these bills is the physician's number, not the hospital's.

However, for other sorts of public outpatient providers it may be possible to track beneficiary usage. Federally-funded Comprehensive Health Centers and rural health clinics have their own provider identifiers in the HCFA provider of service file. However, it is not clear whether the Part B carriers use these numbers or assign their own provider numbers to these clinics in the same way that they do to other physician practices. Commission staff will investigate this further.

Others

The Panel suggested two other approaches to measuring access to care that will require considerable additional developmental work prior to implementation. First, episodes of care might be used to track adequacy of access. For example, individuals hospitalized with a heart attack should be seen by a cardiologist after discharge from the hospital. Lack of such followup care could be an indicator that beneficiaries do not have adequate access to care. Second, excess mortality is one poor outcome that may be linked to inadequate access. HCFA routinely releases case-mix-adjusted mortality data for hospitals. Similar indices may be constructed for populations using the date of death available on the Health Insurance Master File.

SUMMARY OF VULNERABLE POPULATIONS, GEOGRAPHIC AREAS, AND MEASURES OF ACCESS

Table 1 summarizes some of the above discussion on vulnerable populations, geographic areas, and measures of access using HCFA administrative datasets.

Table 1. Summary of Geographic Areas, Vulnerable Populations, and Measures of Access

	Proportion of Beneficiary Population	Directly Identifiable from HCFA Administrative Data?
AREAS		
Frontier Rural	1.2 percent	Yes
Inner City	Data not yet available	Yes, by ZIP code
HPSA	Data not yet available	Probably yes[a]
Areas w/ Large Fee Reduction	Data not yet available	Yes
Areas where Medicare Fees are Lowest Relative to Other Payers	Data not yet available	Yes
POPULATIONS		
Old old	Approximately 10 percent	Yes
Disabled	Approximately 10 percent	Yes
Mental	Data not yet available	Perhaps w/SSA Data[b]
Other	Data not yet available	Perhaps w/SSA Data
ESRD	Less than half percent	Yes
Institutionalized	Data not yet available	No
Dual Eligibles/QMBs	Approximately 9 percent	Yes
Non-whites	Data not yet available	Yes
Poor	Data not yet available	No
No Medigap	20 percent	No
MEASURES		
Sentinel Events	Small percentage	Yes
Stage of Disease	Small percentage	Yes, using ICD-9-CM codes
Excess mortality	Small percentage	Yes
Number of Physicians	100%	Only after 1/1/92[d]
Use of Public Providers	Data not yet available	Possibly
Episodes of Care	Data not yet available	Yes
Primary Care Utilization	Large percentage	Yes

Notes:

[a] An approximate ZIP code crosswalk can be obtained by overlaying physical maps of HPSAs with ZIP code maps.

[b] The mentally disabled may be identifiable through patterns of service use (e.g. psychiatric services).

[c] The institutionalized may be identifiable through patterns of service use (e.g. nursing home care).

[d] It may be possible to crosswalk the new unique physician IDs to the carrier-assigned IDs to produce trend data.

TECHNICAL NOTES ON SOURCES AND USES OF DATA FOR MONITORING ACCESS

This section of the Appendix describes several sources of data and their potential uses in monitoring access to care. The core of HCFA's data collection efforts is the Common Working File (CWF), which is described in detail in the first section. Following that, data sources that are immediately available for monitoring access are detailed. Finally, data sources available only in the longer term are described.

THE COMMON WORKING FILE

The Common Working File (CWF) is the core of HCFA's information systems. All Part A and Part B claims processed on behalf of beneficiaries end up in the CWF. In addition to identifying the services and payments, each claim also identifies the beneficiary and provider. Other files allow detailed information on beneficiary and provider characteristics to be merged with the claims information in the CWF.[1]

The CWF is a relatively new system for aggregating claims information. A small portion of 1989 claims were processed through the CWF, as were a significant portion of 1990 claims. As of January 1, 1991, all Part A and Part B records were maintained through the CWF.

The CWF represents a substantial improvement over prior HCFA information processing systems. For the first time, all Part A and Part B claims lines are maintained in a single centralized location at HCFA in Baltimore. Claims processing has also been streamlined, and the HCFA Office of the Actuary indicates that claims run-out times have been cut in half. That is, the percentage of claims processed within six months of incurred date under the CWF is equal to the percentage of claims that had been processed within a year of the incurred date under the old payment record system.

The CWF is also set up for much more rapid data retrieval. First, records for the standard HCFA five percent beneficiary sample are kept on-line (or "near-line") and are readily accessible to HCFA staff. Second, HCFA has established a "prospective tap" process, where every accepted CWF transaction (ie., every clean claim, paid or denied) is

[1] Beneficiary information comes from the Health Insurance Master (HIM) file. Information on institutional providers comes from the Provider of Services (POS) file. Information on physicians comes from the Medicare Provider Identification and Eligibility System (MPIES), also known as the Unique Provider Identification Number (UPIN) file.

screened and copied to on-line databases based on beneficiary ID, physician ID, ZIP code, or other factors. Thus, claims for specific subsets of the population can be monitored on a flow basis.[2]

The CWF will also retain more information than previous HCFA data processing systems. For the first time, line-item detail for all Part B claims is retained. Of particular interest, diagnosis codes (ICD-9-CM) are recorded on the claim, up to 3 (possibly 4) on each bill describing the patient's general condition, and one additional diagnosis for each procedure billed. However, the accuracy or completeness of the diagnosis coding is not clear at this point, and Commission staff will inquire further into this.

The downside of the CWF is that it is huge. A current estimate is that all Part B bills for 10 percent of beneficiaries for one year would require at least 175 standard reels of computer tape, and possible many more. Further, HCFA may not have much spare capacity within their data processing center to generate substantial new files.[3]

SOURCES AND USES OF DATA FOR IMMEDIATE MONITORING OF ACCESS

This section of the appendix briefly outlines some strategies for monitoring access to care that might be put into place in time for the January 1, 1992 implementation of physician payment reform.

Write-Off Files From The Common Working File

First, it should be relatively straightforward to obtain access to records for the standard HCFA five percent beneficiary sample[4], either directly or by requesting summary statistics from HCFA. This may not be adequate, however, for some of the smaller vulnerable populations identified by the Panel (eg., individuals in HPSAs), for analyzing subsets of the vulnerable populations, or for applying some of the measures of access that depend on fairly rare events, such as the sentinel events.

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[2] For example, claims for the 25,000 beneficiaries in the Current Beneficiary Survey sampling frame are cumulated on a weekly (Part B) or monthly (Part A) basis. At the present time, this is the largest such "prospective tap" that HCFA has installed within the CWF system.

[3] HCFA is doing a considerable amount of CWF data processing on behalf of the Agency for Health Care Policy and Research, which in turn transfers several million dollars per year to support HCFA data processing efforts. It is not clear what priority non-paying requests would have.

[4] Five percent of all non-ESRD beneficiaries, and 100 percent of ESRD beneficiaries. This amounts to roughly 1.7 million beneficiaries.

Second, the Commission might request that population-specific files be created on batch basis from the existing 1991 CWF records and on a "prospective tap" basis for the 1992 records. This would require some negotiation with HCFA data processing staff and others, and the size of the population so sampled would be constrained by some notion of feasibility and reasonableness.

One approach to monitoring access immediately after January 1, 1992 would be to request a sample of records from the Common Working File on a flow basis. That is, all Part A and Part B records for selected areas or populations could be written to tape cartridges on a weekly or monthly basis for analysis.

While this is technically feasible, it would involve a substantial amount of work, both at HCFA and at the Commission. The largest "prospective tap" currently in place in the CWF system collects records for approximately 25,000 beneficiaries, or less than 0.1 percent of the beneficiary population. It might be possible to acquire information on substantially larger samples of beneficiaries, particularly if we restrict the sampling to sub-samples of the standard HCFA 5 percent beneficiary sample. However, the cost of collecting and processing the data would grow accordingly.

Use Of HCFA Summary Data

An alternative to the detail of the CWF would be to analyze summary data provided by HCFA. Utilization information for some of the geographic areas (eg., payment areas) and population types (eg., disabled, ESRD) may be tabulated on a routine basis by HCFA. However, this information is likely to be in terms of gross outlays or outlays by type of service, and we are not likely to be able to track the more refined measures of access.

Currently, most HCFA summary data are of two types. First, there are a number of annual summary files produced. These typically track outlays by geographic area and broad beneficiary population groups (eg., age categories). Typically, these files have been available only with a considerable lag, often several years.

A second set of summary statistics consists of carrier workload reports and Treasury outlays. These are often produced monthly, but are on paid basis, that is, they reflect the number of claims processed, not the amount of care delivered at any one time. Typically, these reports would reflect only gross aggregates such as total expenditure by type of service.

The Commission may wish to explore developing an arrangement with HCFA to generate some more detailed and timely summary statistics. For example, there are only about 10 million Part A final bills submitted each year. Measures of access based on Part A utilization (eg., some of the sentinel events) might be tracked fairly easily and quickly and on a reasonably detailed basis.

Surveys Of Beneficiaries And Physicians

An alternative to claims data for monitoring of access in 1992 would be surveys of beneficiaries or physicians.

Surveys of beneficiaries may be an important source of information on the immediate effects of payment reform. Staff contacted the American Association of Retired Persons (AARP). Although AARP used to do annual surveys on a wide range of issues concerning older Americans, it is now moving to custom surveys on special topics. AARP staff have expressed willingness to explore cooperation with the Commission in this area.

Rather than rely on existing surveys of beneficiaries, the Commission may wish to undertake its own surveys to obtain immediate feedback on physician payment reform. To obtain reliable estimates for the geographic areas and vulnerable populations discussed above, this would require a fairly substantial sample of beneficiaries. The Commission may wish to contract with national survey organizations for a large-scale survey of beneficiaries.

Physician organizations are another potential sources of information on the immediate impact of payment reform. Staff identified four organizations who have recently surveyed physicians: the North Carolina chapter of the American Society of Internal Medicine (NCSIM), the American Academy of Family Physicians, the Minnesota Medical Association, and the American Medical Association. The American Medical Association is currently doing research on the access issue, and may introduce access measures in it the physician surveys that it routinely fields. The American Urological Association is also conducting a large survey of its membership on access and other issues. This is not an exhaustive list, and there are probably other significant physicians survey projects of which Commission staff are unaware.

Beneficiary Focus Groups

A final option for immediate feedback on the impact of payment reform would be to organize beneficiary focus groups. The Commission has had some success (using Mathematica Policy Research as a contractor) in conducting some focus-group type work in developing a Commission survey of beneficiary understanding of assignment and participation in the Medicare program. However, this option probably would not lead to easily quantifiable data.

SOURCES AND USES OF DATA FOR LONGER-TERM MONITORING OF ACCESS

The principal difference between the short-run strategies mentioned above the strategies available in the longer run is that several detailed datasets will become available in late 1993 or early 1994. These would include the following:

Part B Medicare Annual Data (BMAD) Files

The Part B Medicare Annual Data (BMAD) file system consists of annual summaries and samples of Part B non-institutional claims. Currently, each carrier submit its BMAD files to HCFA, which then edits and combines the carrier submissions to generate national files. The BMAD files typically are released one year after the close of the calendar year. HCFA staff plan to continue to generate BMAD-like files from the Common Working File data. It is not clear at this point whether any of the new information available in the CWF record (eg., diagnosis code) will be added to the BMAD records.

There are four separate BMAD files. The first (BMAD-I) summarizes all Part B claims (other than facility charges) by carrier, physician specialty, and CPT code. Thus, with some modification, this file could be used to calculate area-specific utilization rates for carrier charge localities. It could not, however, be used to examine utilization for smaller areas (eg., HPSAs, ZIP codes). The second (BMAD-II) is the list of prevailing charges across the various carrier charge localities. It will become obsolete after the Medicare Fee Schedule is introduced. The third (BMAD-III) contains all claims lines for a five percent sample of all providers, while the fourth (BMAD-IV) contains all claims lines for a five percent sample of beneficiaries.[5]

Medicare Provider Analysis And Review (MEDPAR) File

The MEDPAR file contains all Part A inpatient discharge abstracts for a fiscal year. These records retain multiple ICD-9-CM procedure and diagnosis codes, as well as other information such as length of stay and discharge status. In addition to the standard MEDPAR file, a relatively new file called the QC-MEDPAR exists. This file contains additional information concerning readmission and death after discharge from the hospital. These records are available for the universe of Medicare beneficiaries.

Survey Data

Data from two national surveys should be available in the years after 1992. These are the Current Beneficiary Survey (CBS) and the Health Interview Survey (HIS).

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[5] Plus 100 percent of all ESRD beneficiaries.

Some aspects of the data are common to both surveys. First, the sample sizes are small enough to preclude some levels of analysis. For example, the CBS will sample about 12,000 Medicare beneficiaries, while the HIS sample contains roughly the same number of individuals over age 65. This would make estimates of some sentinel conditions, smaller vulnerable populations, and smaller areas relatively volatile across years.

Second, both surveys contain health status and health care utilization information. For the HIS, that information is based on the recall of the respondents. For the CBS, claims information from the Medicare statistical system will be appended to the responses. In addition, the CBS will contain a series of questions aimed directly at changes in access.

Other Non-Medicare Trend Data

A further option in the long run would be to track expenditures and utilization for populations other than Medicare. Several sources of non-Medicare data may be available.

State Hospital Discharge Abstract Data. Currently 29 states have some mandate to generate hospital utilization information. However, only about 14 states generate usable hospital discharge abstract files.[6] In addition, this information is generally available only with a considerable lag. For instance, no state has a 1990 file yet available, several states have 1989 files, but the majority of states have only a 1988 or earlier file available.

One possible alternative to the use of state hospital discharge abstracting systems is the Commission on Professional and Hospital Activities (CPHA) data. CPHA collects hospital discharge abstract information on a very timely basis from some of its member hospitals. However, the sample of CPHA reporting hospitals is not uniformly distributed across areas, and it may be difficult to generate population-based use rates from these data.

The MEDSTAT Data. MEDSTAT gathers claims for the employees of approximately 100 large organizations and analyzes those claims for their client organizations. MEDSTAT currently produces about 30 million outpatient claims annually, with a reasonably even geographic distribution across urbanized areas of the U.S. They claim to be able to generate good national use rates, but cannot generate reliable state-level utilization rates for much of their data. However, for about half of their data, they can generate population-based utilization rates for sub-national areas.

The HIAA Data. The Health Insurance Association of America (HIAA) produces data showing submitted and covered charges for a number of procedures. However, those data

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[6] This information comes from a recent telephone survey conducted by Greg Dodds of Consolidated Consulting Group. Many of the largest states have discharge abstract datasets, including New York, California, and Florida.

have generally been used for pricing purposes, and it is not clear that good utilization rates can be calculated from them.

National Center for Health Statistics. The NCHS gathers information on a number of important medical services for a sample of the U.S. population using the HIS and other sources. These data may be sufficient for national comparison with Medicare trends.

Other. Other payers may be willing to provide data for their populations. The Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) is national in scope and maintains detailed utilization files on its enrollees. Similarly, the Federal Employees' Program (FEP) is the national Blue Cross and Blue Shield insurer for Federal employees. It too collects detailed claims information across the United States. Commission staff have not contacted either of these institutions yet to inquire about data availability.

SUMMARY AND TENTATIVE WORKPLAN

This appendix has described in detail many feasible approaches to monitoring access both immediately and in the longer run. The Commission is now considering its options for monitoring access.

Clearly, the first focus of work must be on access measures to be put into place prior to the implementation of physician payment reform. The phase-in of the Medicare Fee Schedule is now less than a year away, and any action that will be taken to monitor access in the short run must be planned and implemented now.

In terms of data sources, at this juncture probably the most reasonable approach is to concentrate on readily available HCFA claims datasets. Part B claims for the standard 5 percent beneficiary sample, and Part A claims for all beneficiaries are both large but manageable files. Thus, analysis for the first year may focus on these two files.

Much work needs to be done to validate the numerous proposed measures of access using existing data. Existing historical files (the BMAD and MEDPAR files) provide claims information for 5 percent of Part B and 100 percent of Part A claims. Thus, these historical files can be used to examine the validity and reliability of the various measures of access discussed here. Once having settled on a reliable set of measures, the Commission may pursue obtaining more recent data from HCFA and tracking trends in these measures of access.

The Commission will also examine the availability of beneficiary and physician survey data. While probably less precise than claims files, such data could provide a meaningful and timely supplement to claims-based analysis.

Finally, the Commission reiterates its belief that HCFA should routinely report detailed Part A and Part B utilization statistics in a manner that will allow other interested parties to assess changes in beneficiaries' access to care. A common set of data available to all would enhance dialogue on beneficiaries' access to care and preserve confidence in the Medicare program.

REFERENCES

Department of Health and Human Services, *Report to Congress: Monitoring Changes in Use of, Access to, and Appropriateness of Part B Medicare Services*, U.S. Department of Health and Human Services, Washington, DC, 1991.

Health Resources and Services Administration, *Incorporating Health Status Indicators into the Measurement of Medical Underservice*, Contract Number 240-86-0056, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services, Washington, DC, 1987.

Physician Payment Review Commission, *Medicare Volume Performance Standard Rate of Increase for Fiscal Year 1991*, Washington, DC, 1990.

United Hospital Fund of New York, *Measuring Avoidable Deaths and Diseases in New York State*, United Hospital Fund of New York Paper Series 8, January 1988.

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